Clinical Sociology Review

Volume 10 | Issue 1 Article 10

1-1-1992

Using Sociology to End Chemical Dependency

J. Barry Gurdin
To Love and to Work: An Agency for Change

Using Sociology to End Chemical Dependency

J. Barry Gurdin, Ph.D.
To Love and to Work: An Agency for Change
San Francisco, CA

ABSTRACT

Drawing on participant observations and interventions while counseling 160 heroin addicts over a two-year period, the author explores the possibilities and limitations of using sociology to counter his clients' addictions to heroin and other drugs. Important historical changes have brought about new conflicting viewpoints within the methadone maintenance clinic, where acupuncture and Chinese herbal treatments are now available alongside Western medicine Although sociologists have written harsh accounts of "getting the treatment," they have tended to support methadone maintenance, which has been demonstrated to stem crime and HIV, among other socially beneficial ends. Clinical sociologists can resocialize addicts to mentally-healthful social solidarities, demystify the socially destructive effects of drugs, and criticize ineffective, dehumanizing treatment techniques and ideologies

When a counselor sits down with a client who is a heroin addict attempting to heal or to cope with addiction, a sociologist would identify these two people as taking part in a definable status-role relationship. Specifically, the status of a counselor is attached to the roles of active listener, monitor

Presented at the Annual Meeting of the Sociological Practice Association and ISA Working Group in Clinical Sociology, 5-9 June 1991, Costa Mesa, California.

of randomly taken urinalysis tests, supportive inquirer into a person's history and current well-being, compiler of legal files pertinent to the client's program compliance, and challenger of irrational thoughts, reasoning, and actions which contribute to the person's addiction. In comparison, the status of a person under treatment in a methadone-maintenance clinic is assigned to the role of a client who must follow the rules of the methadone-maintenance program—the very admission to which is frequently required by an agent of formal social control, such as a parole officer, or by the client's own desire to cope with or end his or her addiction to heroin and other drugs. Thus, the client is frequently defined by society as a criminal, either because the client has been apprehended for a felony or misdemeanor, such as burglary, related to supporting his or her addiction, or because society has defined dependence on extremely addictive substances as a serious offense. In brief, from the earliest studies of addiction, sociologists have frequently pointed to the Harrison Act as a major factor in creating what is identified as the pattern of normatively disapppoved behavior associated with addiction to heroin, morphine, and other opiates. They argue that by preventing legal access to these drugs, the Harrison Act and other related legislation drove up the price of these substances and forced their production, distribution, and exchange into the market of organized crime (Clausen, 1976, pp. 140-78, especially pp. 168-70; Duster, 1970).

In the current debate over the war on drugs, we see an unusual alignment of camps, where rightwingers, liberals, conservatives, and leftwingers find themselves in political agreement with their ideological opposites on the question of the regulation of drugs. One side favors stronger regulation; the other legalization of drugs. Both positions claim that their policies would do away with the worst effects of drugs on society. A progressive point of view falling between the two extremes of legalization or repression of drugs, is decriminalization of drugs, and this position appears to be gaining ground (Eisenberg, 1991).

From Emile Durkheim (1967), sociologists have learned that a society's laws reflect its deepest moral judgments. In a highly complex society such as our own, these laws are meticulously encoded in writing on the printed page, and now are even stored and processed electronically, while still reflecting the organic solidarity which they express. The U.S. Federal Government, through the Department of Health, Education, and Welfare's Food and Drug Administration, formulated guidelines for the regulation of methadone use in the early 1970s. Joel Martin Shteir observes that these regulations increased the control of the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs over all methadone programs (1975, pp. 34-35). In California, the most populous state in the nation, with its 30 million inhabi-

tants, society's judgments about drug use are expressed in Title 9, California Code of Regulations, (Anonymous (a), 1983), and its norms regarding methadone treatment programs in particular are encoded in the regulations in Subchapter 4 beginning on page 786.4. Every activity surrounding this opiate is minutely outlined. Such detail signifies the danger which society has ascribed to this drug and its impact on its well-being. Some investigators have claimed that the degree of social mobilization against drugs at various times in American history can only be understood by putting these social movements into the context of society's emphasis on the Puritan values of hard work, sobriety, and the acquisition of material goods in this world as a sign of salvation in the world-to-come, and thus to an extreme devaluation of substances which deflect human action away from such values (Larner, 1991; Massing, 1991).

There are several levels at which sociologists have applied their skills in the area of substance abuse. At the most prestigious and well-paid level, a handful of sociologists have acquired very large grants to study the patterns of drug intervention on a national scale (Biernacki, 1986; Feldman, 1973; Robins, 1985). Others have obtained smaller training grants for study of a particular research question, for a limited amount of time (Coombs, Fry, & Lewis, 1976). Still others have specialized in descriptive qualitative studies of the quickly changing drug subculture (Becker, 1963; Lidz & Walker, 1980; Rosenbaum, 1981; Stoddart, 1991), or have applied methodologies to analyze drug-related data (Gurdin & Jeremy, 1987; Gurdin & Patterson, 1987; Guttman, 1982; Levy, 1989) or psycho-social interventions (Watts, 1988).

In this essay, I have drawn on the works of several sociologists as applied to the issue of counseling drug-dependent individuals. Particularly helpful were Robert Sévigny's publications which applied Carl Rogers's psychological insights to a variety of fields of sociological research (Sévigny & Rhéaume, 1988a, 1988b), and Hans Peter Dreitzel's (1977) critical sociology of roles. In the clinics where I have worked, the chief clinical psychologist has been inspired by the work of Albert Ellis, and has encouraged counselors to employ Rational Emotive Therapy, which shares many common assumptions with cognitive sociology (Ellis, McInerney, DiGiuseppe, & Yeager, 1988).

The Social Context in Which Sociology was Used to End the Chemical Dependencies of Clients

When I speak of having used sociology to end the chemical dependency of clients, let me emphasize that I have drawn on sociology within a particular, institutionalized context which has imposed extreme constraints on

its use (Fagan, 1991). The context is that of methadone maintenance clinics in the Bay Area. All counselors in the two clinics in which I have worked are required to meet a caseload of forty clients at least twice a month, for a minimum of fifteen minutes per session, and to write up casenotes on each of these meetings. Most of my sessions last considerably longer, on the average between 30 and 120 minutes per session, depending on the client. The clinic cares for approximately five hundred clients, and has detoxification ("detox") and maintenance divisions. When the random urinalysis results are available on a listing, they are recorded in the chart by the counselor, who must ask the client for a response if the test result reveals the presence of any substance other than methadone and methadone metabolite.

After the counselors have done an initial clinical assessment—which is basically an extensive life history, focusing on the client's drug use—they compose an initial treatment plan (TP), which is divided up into three areas: the identification of a problem; defining goals for change associated with the problem; and specifying means of action into which these goals are concretized. These treatment plans are sectioned into nine content areas, of which only a few are actually spelled out in any individual's TP. The State of California requires the counselors to revise these treatment plans every quarter. The nine content areas are as follows: 1) drug use; 2) medical; 3) legal; 4) psychosocial; 5) educational/vocational; 6) program compliance; 7) housing; 8) financial; and 9) AIDS education. A problem, goal and action step statement corresponds to each of these content areas. In addition, the frequency of counseling, the contract types and durations, the urinalysis results during the last three months, methadone dosage, current take-home status, the client's name and I.D., his or her start date, an effective date, and the client's, counselor's, physician's and reviewer's signatures must be recorded within a rigidly specified length of time. At a later date, a supervisor or chart reviewer may make comments during a review which must be formally replied to by the counselor. The rigidity of these requirements means that a great deal of time must be spent on clerical details before the actual counseling process may even begin.

In the context of the methadone clinic, the counselor promotes a process of change away from the use of illicit drugs, primarily by exerting social control by means of the introduction of informational change at the individual and group level (Grawitz, 1972, pp. 855-890). By introducing new information, which frequently contradicts old information, the counselor promotes changes in thoughts (cognitions) and feelings (emotions) about drugs.

By the time a heroin addict has enrolled in a methadone maintenance program, she or he has often begun to employ the addiction to heroin and/or other substances and a role based upon this addiction as a means of defense, attack, or adjustment to the overt and covert problems created by the consequent societal reaction to the addict. Edwin M. Lemert identifies such deviation as secondary (1981, p. 196), and Jeanette Covington's Ph.D. thesis (1979) is particularly relevant to this process for chemically-dependent clients. The task of the clinical sociologist is to record the complicated process by which a client's deviation has become secondary and to reverse those attitudes, beliefs, and overtly illegal acts which result in extremely punitive societal reaction to the client, while providing emotional support to the client as a person who is worthy of others' care and affection. The DSM-III-R psychosocial stressors discussed in the paragraphs below provide a convenient checklist of life areas where primary deviance often evolves into secondary deviance.

I frequently use two exercises to help clients to understand where their drug use has led them and to help them realize that it is possible for them to break free of their dependence on heroin and other illicit drugs. In the first of these exercises the client is asked to compile a list of the ten worst things heroin has done to them. After discussing this list—which frequently reveals the client's path to secondary deviance—I ask the client to carry the list with them at all times and to read it and reflect on it whenever they have a craving to use drugs. They frequently acknowledge that such acts as stealing from family or physically or verbally abusing friends or employers—influenced by the highs and lows of their drug use—are unacceptable behavior—even when such acts are a response to others who have harmed them. They may want to apologize or offer amends to those they have hurt. A second exercise I often incorporate into my clients' treatment plans urges them to draw a picture of themselves as a "dope fiend" and another of themselves as a "drug-free person." Frequently these sketches depict an unhappy, unhealthy, lonely drug user and a happier, healthier, more sociable drug-free individual. These drawings are useful to combat the false belief—"once an addict, always an addict"—that may undermine the efforts of long-time users to end their drug dependence. To counter this same false belief among my more highly-educated clients, I ask them to read and discuss Patrick Biernacki's (1986) book, or I refer them to Marsha Rosenbaum's work (1988).

As a clinical sociologist, my treatment plans frequently identify DSM-III-R psychosocial stressors, considered along Axis IV, which need to be changed if drug use is to stop. Employing these DSM-III-R stressors avoids the problem of "the physical and emotional dimensions of human experi-

ence" which Hans Peter Dreitzel finds lacking in Jürgen Habermas's "theory of the evolution of human competence" (1979, p. 117). The first such stressor is conjugal. Not infrequently, a partner of one of my clients ends up incarcerated—leaving my client to deal with this separation. This may sometimes be a good point at which to reevaluate the relationship. Here it is necessary to decide whether the client's relationship contributed to, is neutral toward, or helped to end his or her drug use.

Developmental stressors in my client's life may include such factors as Late Luteal Phase Dysphoric Disorder (DSM-III-R) or a teenager at home whose drug use is driving my client to decompensate. Here it should be noted that my sociological knowledge is not accessed independently of my knowledge of the psychology or biology of addiction. For example, the psychological observation that addicts have a low frustration tolerance may lead me to expect that a female client who is a heroin addict may experience a higher level of pain during Late Luteal Phase Dysphoric Disorder than a non-addict. A family session in which poor nutrition is revealed may suggest that dietary change may be an area where the counselor may refer a client to books, nutritionists, or other resources in order to decrease the severity of this kind of stressor. For example, sugar is often found to be a large part of my clientele's diet. When this is the case, I refer my clients to a book written by medical doctors (Phelps & Nourse, 1986) or a popular nutritionist (Lappé, 1982). If the client is a poor reader, I verbally summarize this information for them and monitor their change in diet.

In the area of family stress, it is sometimes necessary to request that clients set limits on family members who cause physical danger or harm to the family system. Thus, when one of my clients would not permit her crack-addicted teenager to enter her home until this person entered treatment for or ended his addiction, calmer bodily cues from the client and her young children were immediately noticeable. Moreover, as long as this constraint was upheld, her urinalysis results remained free of illicit opiates.

Most of my clients live under constant financial stress. To a client of mine who was homeless until taken off the streets by a crack dealer, it was not apparent that the crack dealer was using him as a customer and that his addiction to crack cocaine was the major cause of his homelessness until this counselor suggested it to him. Often clients must be reminded that if they had not spent $125 on a gram of heroin in one day, they would have had $87.50 to pay two weeks of fees for their methadone clinic, and additional money to pay rent, purchase clothes for themselves, and their families, and eat on a regular basis.

My clients often also have legal stressors which constrain their freedom. By referring them to free or moderately-priced legal aid, or by writing,

speaking or meeting with their parole officers or lawyers, I have been able to help, for example, a client end a debt to a dead person for which he was still being pursued by the law.

By taking my clients' occupational stressors, particularly unemployment, seriously, I frequently met the opposition of other counselors trained in marriage and family counseling or psychiatry (see also Lidz & Walker, 1980). These colleagues frequently argued that the client was not ready to go back to work and that coming to terms with their addiction was the client's primary job while in recovery. I do not dispute that recovery is hard work or that dysfunctional action influenced by addictions may impair or impede job performance. However, as a sociologist, I am particularly sensitized to the importance of work in imparting meaning, structure, identity, and some measure of economic security to an individual. Many of my clients hold down jobs performing essential work for our society, from building buildings to providing legal and other professional services. The socio-economic class demographics of my clients has been similar to the breakdown of Patrick Biernacki's interviewees (1986, p. 173).

I have attempted to draw upon other interpersonal stressors to focus my clients on the impact of these stressors in the ongoing meaning of their lives. One of my current clients lost a friend to lung cancer. Like my client, this person had smoked tobacco cigarettes. Before the death of his friend at a relatively young age, my client had never considered giving up smoking, nor the relationship of his recovery from heroin addiction to his addiction to smoking tobacco. By providing information on the health risks of smoking tobacco and by pointing out an older client at the clinic who has a severe case of emphysema, my client was persuaded to consider joining a smoking cessation group.

Other psychological stressors that frequently arise are death and rape. Some of my clients have lost many friends and intimates to HIV. One of these clients recently noticed several bodily indicators that made him think he had the disease. Despite months of trying to persuade this individual of the advantages of early detection and intervention through periodic testing, he resisted being tested for HIV. When he finally was tested, he was certain that the results would be positive, and began to plan his own demise. I emphasized the irrationality of jumping to conclusions before he had the results of the test, the need to be retested to confirm the results whatever they might be, and the many changes that this individual and his partner could make to live prolonged, higher quality lives. When it turned out that this person and his partner both tested negatively, despite his foreboding, I tried to use this "new lease on life" (to use his terminology) to exhort the

client and his partner to make changes to ensure the client's freedom from illict substances and to promote their greater well-being.

The stressor of parenting frequently exerts influence on a client to use illicit substances. One of my clients who more than a year previously had been placed on a contract to never again tamper with his urinalysis test, came up with a second incident of this nature. This client's wife, who was addicted to crack cocaine, had just returned to his apartment after many years' absence and left their two children with my client, after stealing one of his few valuable possessions. At the same time, this client discovered that he needed to begin treatment for a serious disease. After becoming primary childcare provider for his children, this client, who had been clean of illicit drugs, suddenly began to come up "dirty" for these substances. At this clinic, the director interprets contracts dealing with tampering literally, and such an incident leads to the termination of the client, subsequent to a thirty day period of gradual detoxification from methadone. Although I pleaded that this individual suffers from short term memory loss, he will most likely be terminated. In attempting to make the best out of the situation, I have tried to persuade this individual to get on another treatment program.

Social control of clients by their counselors is accomplished through a counselor's verbal and non-verbal communication of approval or disapproval, or more formally through the mechanism of written contracts. For example, this counselor recently led a small group discussion about the negative impacts of drugs on community life. All of the participants reported and acknowledged that life in their neighborhoods had become more dangerous; shootings, stabbings, woundings, stealing, and murders had increased tremendously. Denizens of neighborhoods had begun to lock and bolt down their houses, cars, and all possessions more frequently than when there were fewer drugs. Trust in one's neighbors had declined precipitously. Yet, many of these same participants tacitly or explicitly confided that they had engaged in similar activities which undermined the quality of community life. When challenged to explain their belief that they had to sell drugs to get any satisfaction out of life, these clients retorted that if they did not sell drugs then someone else in or outside their communities would make the large profits to be made in the selling of drugs. While acknowledging that the clients might be correct in this matter in an immediate, superficial sense, I stressed that they were actively and unnecessarily making their own lives more unpleasant, dangerous, dysfunctional, and unhappy, when there were alternative methods for these clients to improve themselves and their communities in many different ways. I emphasized that by getting together in community organizations they could come to build trust with their neighbors around specific isssues such as pre-

serving their current level of funding in public education and community services such as park and recreation activities. Yet, in one group I was unsuccessful in persuading my clients that they would be safer if their communities were rid of handguns, AK-47s, and Uzis or if the police were able to effectively control the trade in guns and highly addictive substances. In contrast, however, limited to the verification of a client's self-report, I was successful in convincing one client that Child Custody and Protective Services would be less likely to take his beloved child if he were to dispose of or put under lock and key all of his plentiful firearms and keep them out of the child's reach. Furthermore, after citing statistics on domestic violence, I convinced this man, who was a graduate of one of America's top prisons, it would be less likely that he himself would be injured or killed during his partner's unpredictable alcoholic binges, and would be under less suspicion by the law, if he had no accessible weapons.

As an example of how these stressors relate to the unlearning of secondary deviance, I refer to one of my clients who appeared in the national media in September 1991. This client is a successful young writer who recently published an article in a national magazine about tracking down the molester of his son, and how this experience helped him become conscious again about having been sexually coerced by his own father for a number of years (Anonymous 1991, pp. 46-51, 60-61). The client and I agreed that dealing with this fact is an important factor underlying his addiction and have incorporated it into his treatment plan. Unlearning this aspect of his primary deviance has led the client to carefully recollect all the specifics of this experience and to crossvalidate his memories with those of other close family members. It is this counselor's judgment that the client's reluctance to file the necessary child abuse charges against his own father—who is no longer in the proximity of other children—expresses itself in a great stress expressed in his very constricted body language. Yet the client must also learn to avoid covering up his emotions with drugs, which means permitting him to cry and express other feelings in our sessions as well as employing cognitive strategies to discourage the use of drugs. This client is learning to use regular meditation to avoid letting stress take hold of him. Another important way in which the client is attempting to unlearn secondary deviance is by articulating the conflicting messages his most significant other, his wife, is sending him about his career. On the one hand, she has allowed him to be absent a great deal for his writing assignments in dangerous areas and has been tolerant of a fluctuating income. Yet at the same time, she would like him to be near his family in a relatively secure environment and to provide a regular, middle-class income. Finally, we are examining in detail how the client cognitively and emotionally frames the

urge to use drugs, and are promoting replacement of the old thoughts and feelings with new, consciously positive ones. This client uses drugs compulsively by giving into boredom and fatigue at the end of a hard day's work of writing. By asking the client to identify a physical activity which he enjoys, this counselor has encouraged him to engage in this physical activity at this time of day, no matter what his other thoughts and urges might be. These techniques have been identified as the inception of cure and the beginning of the addict's "self-in-transition" (Ray, 1976).

To summarize, within the methadone clinic, a clinical sociologist working as a counselor is constrained by legally- and clinically-defined limits of the setting to draw on sociology at the microsociological level of the individual and small group and only within the framework of specifically-defined time limits and charting. Even within these narrow limitations, the application of sociological knowledge can be predicted to generate conflict with other counselors trained as psychologists, marriage, family, and child counselors (MFCCs), or psychiatrists because collective attributes are frequently denied or understood as obstacles to overcome individually. Moreover, at some clinics, trying to get clients to engage in social solidarities other than religious or quasi-religious group affiliations (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, or Marijuana Anonymous) may be labelled inappropriate professional behavior, while at others, Rational Recovery (RR) groups are actively promoted.

Conflicting Groups within the Methadone Maintenance Clinic

Joel Martin Shteir in his Master of Arts thesis presented to the Faculty of the Department of Sociology at Brooklyn College, found that there are contradictory roles of rehabilitation and social control in methadone clinics (1975, p.35). Following Joel Martin Shteir, Charles W. Lidz and Andrew L. Walker revealed a similar dichotomy when they referred to the medical and outlaw models of the Narcotics Addiction Unit (N.A.U.) (Lidz & Walker, 1980, p. 196). Moreover, one of Shteir's central findings—based on his qualitative observation of Beth Israel's Methadone Maintenance Program clinics—was that "having a professional self-image does appear to be a critical factor in role conflict. Individuals with a professional self-image generally express negative feelings against the one organizational manifestation which best represents the organization's expectations for the respondents, the rules and regulations" (Shteir, 1975, pp.73-74).

Since Joel Martin Shteir made his qualitative observations in New York State in the early 1970s, America and the world have changed dramatically

as have their drug scenes. And, of course, New York's and California's subcultures differed then as they do now. Let me briefly summarize what I see as the structural similarities and differences between Shteir's description of methadone treatment and what I have observed. Firstly, Shteir observed that counselors with a more articulated professional self-image generally felt frustrated in enforcing the methadone organization's rules because they felt it worked against the rehabilitation of their clients. To a large extent, the more highly-educated people had a more professional identity and the less well-educated appealed to a strict construction of the federal regulations. I observed a similar opposition in the clinic where I worked for the longest period of time; however, the ABDs of Shteir's thesis have roughly been replaced by Ph.D.s, marriage, family, and child counselors (MFCCs), family nurse practitioners, and foreign-born MDs, and the less highly-educated by former addicts and non-addicts with M.A.s, or B.A.s.

Secondly, regarding treatment issues, there is a tendency for the more professional to express their case interpretations and recommendations for interventions in more abstract perspectives based in biology, psychology, or the social sciences. However, since Shteir wrote his thesis, codependency theory has exerted considerable influence on work in rehabilitation, and, in my observations, the less professional practitioners have subscribed either explicitly or implicitly to more of the core beliefs of codependency theory than have the more highly-educated professionals. In the next section, I will discuss the development of a critical sociology of codependency theory.

Thirdly, the position of the social sciences has significantly weakened within American mental health practice, despite the American Sociological Association's attempt to deny the *New York Times's* story of "Sociology's Long Decade in the Wilderness" (Berger, 1989).

Toward a Critical Sociology of Ending Clients' Chemical Dependency or Against the Explicit or Implicit Application of Unconditional Negative Regard.

It is not surprising, given the weakened position of sociology and other social sciences since the advent of Reaganism, that two new books by psychologists attacking codependency theory draw heavily on social scientific works (see Katz & Liu, 1991; Peele & Brodsky, 1991). Elizabeth Paeth, M.D., M.P.H., (1988, p. 11) notes that "some definitions of codependency are varied, some very narrow and specific, others quite broad and all inclusive." Quoting Timmen Cermak, she records, "Codependence is a recognizable pattern of personality traits, predictably found within most members

of chemically dependent families which are capable of creating sufficient dysfunction to warrant the diagnosis of Mixed Personality Disorder as outlined in DSMIII" (Paeth, 1988). In contrast to Cermak's specificity, she reviews Sharon Weyscheider-Cruse's definition, "An addiction to another person or persons and their problems, or to a relationship and its problems." Lillian L. Hyatt, M.S.W., (1986, p.85) defines codependency in the following manner: "This term is often applied to any adult who assists in maintaining the social economic equilibrium (for functioning) of any chemically dependent person." A more in-depth analysis of the published usages of codependency has led me to conclude that it directly opposes the most sacred helping actions enjoined by the major ethical and religious traditions of our society.

While Hyatt (1986) and Paeth (1988) may indeed point to kinds of action that need to be changed and resocialized, in observing practitioners utilizing the concept of codependency, I repeatedly watched them refer to this concept to righteously defend their attitude of "Unconditional Negative Regard." By this rubric I reference the clinic director's revelation to me that she could never again counsel these chemically-dependent clients who, she assumes, regularly manipulate, lie, cheat, steal, and physically abuse themselves and others. When challenged with evidence that contradicted her judgment based on this assumption regarding one specific case, her response was, "I don't care what you feel!" A similarly harsh account of social interaction in a methadone maintenance program is offered by Marsha Rosenbaum (1988), Charles W. Lidz and Andrew L. Walker (1980), and Vincent Dole and Marie Nyswander (1976) before the promotion and encodification of such action as a moral good in codependency theory.

"Unconditional negative regard" also points to the irregularity and partiality with which coercive action is undertaken at clinics such as the first one in which I worked. There, the tone set by the clinical director recalled the most totalitarian features of mental health settings depicted by Goffman (1961) and Kesey (1962). Yet such coercive action, from contracts limiting a client's right to be verbally loud or profane in a counselor's office or in the clinic to the ultimate weapon of being terminated from the program—meaning an immediate or short detoxification from methadone—was usually justified in terms of the mentally-healing aspects of setting clear limits and letting a client learn of the inappropriateness of his or her behavior through negative consequences, or by the supervising counselor's desire not to be codependent. When, in case conferences, recent evidence and arguments supporting the expression of anger were presented, they were authoritarianly dismissed without rebuttal being permitted. Michael Lerner recorded, "...once that anger was experienced in a safe context, it did not

get out of hand ... As the anger gets externalized and the self-blaming decreases, the use of various narcotics to deaden pain is less necessary" (1986, p. 162). Yet, this counselor was instructed not to offer such evidence at case conferences.

In this clinic, when counselors spent considerably longer lengths of time with clients than the minimally-required fifteen minutes twice a month, they were labelled as codependent by the clinical supervisor, despite evidence that clients needed and desired longer sessions and profitted from them. In contrast, in the second clinic observed, codependency theory was cited much less frequently by staff as justification for their actions in treatments and the clinical director permitted counselors greater freedom to spend time with clients. The clinical director and supervisor who subscribed to codependency theory applied clinical rules in a very partial manner by constraining or terminating clients or questioning the clinical skills of the counselors whom they did not like. It is notable that these codependency advocates were the harshest in their treatment of staff who were more highly educated. Many staff members at both clinics voiced the opinion that the administration had placed such gatekeepers in powerful positions to atomize staff—particularly along sexual-orientational and racial lines—by using such individuals to prevent social solidarities from forming among staff members which could possibily lead to unionization; and to mollify the implementation of the demographic policy guidelines of state funders. The staff also noted that the administration had hired highly-paid, moderately-educated consultants to insure that collective problems of staff be interpreted as individual or process problems.

Another aspect of unconditional negative regard which I would like to illustrate is the application of immediate, coercive, contractual consequences to punish the abuse of an illicit substance without examining the underlying biological, social, and/or psychological causes of the use or alternative healing strategies that could end the use while minimizing relapse. Marguerite Holloway's very recent review of the study by David A. Regier, director of the division of clinical research at NIMH, of 20,291 people from the general community, from mental hospitals, and from nursing homes and prisons, found that 53 percent of those who abused drugs had a mental health disorder such as schizophrenia, anxiety, or major depression (1991, p. 103).

Despite Holloway's observations, at the clinics where I have worked, after an inital written warning that the goal of the program is to be drug-free and that taking illicit substances is against the rules of the program, clients are subjected to a series of gradually harsher consequences after a second "dirty" urinalysis. Yet, it is virtually impossible to get the clinic

physician or family nurse practitioner to prescribe psychotropic medication unless it is in response to a third or more-frequent urinalysis result that tests positive for cocaine. In this case, they are recommended for a "stimulant detox" which costs approximately $135 a month in addition to the methadone fees, to pay for two antidepressants (Imipramine, also known as Tofranil, and Bromocriptine, also known as Parlodel). After seeing every client who went on the stimulant detox quit using cocaine within a month, and after hearing recurring reports of relief from depression and heightened senses of well-being on the part of clients who had never before been on an antidepressant, I modulated my anti-,anti-psychotropic medication bias. I began to agree with Julia Kristeva, who wrote:

> L'effet adjuvant des antidé presseurs est alors nécessaire pour reconstituer une base neurophysiologique minimale sur laquelle un travail psycho-thérapeutique peut s'amôrcer, analysant carences et nouages symboliques et reconstituant une nouvelle symbolicité (1987, p. 50).

Yet, as a sociologist, I became acutely aware, and then angry, that only the small percentage of my clientele who had Medi-Cal or private means of payment could benefit from the psychotropic medication available through the stimulant detox, even when their scores on the highly-reliable Beck Depression Inventory indicated that their level of depression was severe. When I raised this issue on 5 April 1991, at a course on psychiatric medications given by the medical director of Forensic Services of the Department of Mental Health, Substance Abuse and Forensic Services of San Francisco, California, Rich Myers, M.D., replied that this was a systemic problem, and the nods of many other participants in this seminar and my conversations with them afterwards confirmed that psychotropic medication is unavailable to a very large percentage of our clients who need and would consent to take them. Moreover, DSM-III-R psychiatric evaluations, which are a necessary step in getting Social Security Income (SSI) for our clients, take well over a year to receive and, usually, face three rejections and a court hearing from which a class of lawyers specializing in SSI make their living by charging indigent clients a hefty percentage of their first SSI check.

Despite these realities, in a case conference the typical response to a client who does not fulfill a contract to give two clean urinalysis results in 60 or 90 days is to put that client on a drop-per-dirty contract, if the client's dosage is already at the maximum of 80 mg or a raise-per-dirty contract, usually by 10 mg per dirty, if the client's dosage of methadone is not blocking that individual's use of heroin at a dosage below 80 mg. If the client

suffers from extreme depression, often exacerbated by unemployment, lack of childcare, spousal abuse, gender identity confusion, or life in a ghetto where the dealing of crack, smack, grass, and speed is the largest profitable industry, codependency supporters may become angered when a counselor tries to address these problems as underlying or causing that client's second, third, or fourth dirty. Conceptualized in a manner similar to William Bennett's[1] way of thinking, such problems are frequently ignored by the codependency advocate, who acts by increasing or decreasing a client's dosage, by constraining the client to sign progressively more punitive contracts, or ultimately, by terminating the client from the program.

As Robert Bellah and his colleagues (1986) have so aptly pointed out, therapists who resocialize clients in treatment to believe that they must stand alone as individuals against the harsh realities of a mean world, and they must make changes in their lives to face such a dog-eat-dog reality have contributed significantly to the mindset of the extremely individualistic aspects of American democracy. Codependency theory—academically expressed by such authors as Hyatt (1986) and Shipp, Hyatt, and Coler (1988) with its myth of the capable individual standing up to changes within and fighting against attacks from without in a harsh social world—significantly undermines the collective ties that bond people to a community capable of transforming its social and environmental world in order to maximize mental health and to provide a safer milieu for all members of a community.

NOTES

1. Unfortunately, the prospect of such investment is anathema to the likes of William Bennett. In one characteristically acerbic comment, delivered at Harvard's Kennedy School of Government, Bennett remarked how, "on the left," 'we see whole cadres of social scientists, abetted by whole armies of social workers, who seem to take it as catechism that the problem facing us isn't drugs at all, it's poverty, or racism, or some other equally large and intractable social phenomenon. If we want to eliminate the drug problem, these people say, we must first eliminate the :'root causes' of drugs, a hopelessly daunting task at which, however, they also happen to make their living.'

As drug czar, Bennett worked hard to discredit the notion that drug abuse has root causes. But the issue has not gone away. With 1990 on record as America's most murderous year, the need to address the problems of our inner cities seems more pressing than ever. The conservative policy of benign neglect having failed miserably, it's time for liberals to propose an alternative. Investing in the community would seem an ideal place to begin (Massing, 1991, p. 240)

REFERENCES

Anonymous. (1983, September 3). Title 9, institutions, chapter 4. Department of Alcohol and Drug Programs. Revision Record for Register 83, No. 36, 751-86.

Anonymous. (1991, September/October). Secret touches. *Mother Jones, 16,* 46-51, 60-61.

Becker, H.S. (1963). *Outsiders: Studies in the sociology of deviance.* New York: The Free Press of Glencoe.

Bellah, R., R. Madsen, W.M. Sullivan, A. Swidler, & S.M. Tipton. (1986). *Habits of the heart: Individualism and commitment in American life* San Francisco: Harper & Row, Publishers.

Berger, J. (1989, May 28). Sociology's long decade in the wilderness. *New York Times.*

Biernacki, P. (1986). *Pathways from heroin addiction· Recovery without treatment.* Philadelphia: Temple University Press.

Clausen, J.A. (1976). Drug use. In R.K. Merton and R. Nisbet, (Eds.) *Contemporary Social Problems* (4th ed.) (pp. 140-78). New York: Harcourt, Brace, Jovanovich, Inc.

Coombs, R.H., L.J. Fry, & P.G. Lewis (Eds.). (1976). *Socialization in drug abuse.* Cambridge: Schenkman Publishing Company, Inc.

Covington, J. (1979). *The creation of deviant self.* Doctoral dissertation presented to the Department of Sociology at The University of Chicago, Chicago, IL.

Dole, V. & M. Nyswander. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association, 235,* 2117-19.

Dreitzel, H.P. (1977). On the political meaning of culture. In N. Birnbaum (Ed.), *Beyond the crisis,* (pp. 83-129). New York: Oxford University Press.

Durkheim, E. (1967). *De la division du travail social* Huitième Edition. Paris: Presses Universitaires de France.

Duster, T. (1970). *The legislation of morality: Law, drugs, and moral judgment* New York: Free Press.

Eisenberg, I. (1991, May 26). A way out of the drug war. *This World: San Francisco Chronicle.*

Ellis, A., J.F. McInerney, R. DiGiuseppe & R.J. Yeager. (1988). *Rational-emotive therapy with alcoholics and substance abusers.* New York: Pergamon Press.

Fagan, K. (1991, June 24). Heroin: The forgotten drug; methadone clinics can't keep up with caseload. *Oakland Tribune, Metro Edition, a*10, 1.

Feldman, H. (1973). Street status among drug users. *Society, 10,* 32-8.

Goffman, I. (1961). *Asylums.* New York: Anchor Books.

Grawitz, M. (1972). *Méthodes des sciences sociales.* Paris: Dalloz.

Gurdin, J.B. & C.B. Patterson. (1987). The problem of sample frame in populations called deviant: The case of methadone-maintained women and their infants. *Journal of Community Psychology, 15,* 459-70.

Gurdin, J.B. & R.J. Jeremy. (1987). Problems of generalizing from a sample of a population called deviant: The case of methadone-maintained women and their infants." *Journal of Community Psychology, 15,* 471-80.

Guttman, L. (1982). What is not what in theory construction. In R.M. Hauser, D. Mechanic & A. Haller, (Eds.). *Social structure and behavior,* (pp. 331-48). New York: Academic Press.

Habermas, J. (1979). *Communication and the evolution of society* Boston: Beacon Press.

Holloway, M. (1991, March). Rx for addiction. *Scientific American, 264,* 95-103.

Hyatt, L.L. (1986). *A triangle of ashes. A novelized case history depicting family issues related to substance abuse.* San Francisco: Lifeline Press.

Katz, S.J. & A.E. Liu. (1991). *The codependency conspiracy How to break the recovery habit and take charge of your life.* New York: Warner Books.

Kesey, K. (1962). *One flew over the cockoo's nest.* New York: Viking Press.

Kristeva, J. (1987). *Soleil noir. Dépression et mélancolie* Paris: Editions Gallimard.

Lappé, F.M. (1982). *Diet for a small planet.* Tenth Anniversary Edition. New York: Ballantine Books.

Larner, J. (1991, Spring). Fighting the "war on drugs": A report from the field. *Dissent, 38,* 241-44.

Lemert, E.M. (1981). Primary and secondary deviation. In E. Rubington & M.S. Weinberg, (Eds.), *The study of social problems· Five perspectives.* Third Edition, (pp.195-98). New York: Oxford University Press.

Lerner, M. (1986). *Surplus powerlessness: The psychodynamics of everyday life . . And the psychology of individual and social transformation* Oakland, CA: The Institute for Labor and Mental Health.

Levy, S. & L. Guttman. (1989). The conical structure of adjustive behavior. *Social Indicators Research, 21,* 455-79.

Lidz, C.W. & A.L. Walker with the assistance of L.C. Gould. (1980). *Heroin, Deviance and Morality.* Beverly Hills: Sage Publications.

Massing, M. (1991, Spring). Can we cope with drugs? A few modest proposals. *Dissent,* 38, 236-40.

Paeth, E. (1988). The medical impact of co-dependency. In D.O. Shipp, L. Hyatt & M.A. Coler, (Eds.), *Family issues and substance abuse program journal,* (pp. 10-14). San Francisco: San Francisco State University.

Peele, S. & A. Brodsky with M. Arnold. (1991). *The truth about addiction and recovery: The life process program for outgrowing destructive habits* New York: Simon and Schuster.

Phelps, J.K. & A.E. Nourse. (1986). *The hidden addiction: And how to get free.* Boston: Little, Brown, and Company.

Ray, M.B. (1976). The cycle of abstinence and relapse among heroin addicts. In R.H. Coombs, L.J. Fry & P.G. Lewis (Eds.) *Socialization in drug abuse,* (pp. 387-99). Cambridge: Schenkman Publishing Company, Inc.

Robins, L.N. (Ed.). (1985). Studying drug abuse. *Series in psychosocial epidemiology* (Vol. 6). New Brunswick, NJ: Rutgers University Press.

Rosenbaum, M. (1988). *Women on heroin* New Brunswick, NJ: Rutgers University Press.

Sévigny, R. & J. Rheaume. (1988a). Sociologie implicite de l'intervention en santé mentale I. *Les pratiques alternatives. Du groupe d'entraide au groupe spirituel.* Montréal: Editions Saint Martin.

Sévigny, R. & J. Rhéaume. (1988b). Sociologie implicite de l'intervention en santé mentale II. *La pratique psychothérapeutique. de la croissance à la guérison.* Montréal: Editions Saint Martin.

Shipp, D.O., L.L. Hyatt & MA. Coler. (1988, Fall). *Family issues and substance abuse program journal* Center for Interdisciplinary Programs, School of Behvioral and Social Sciences, San Francisco State University.

Shteir, J.M. (1975). *Counselor-patient conflict in methadone clinics An exploratory study* A master's thesis presented to the faculty of the Department of Sociology, Brooklyn College.

Stoddart, K. (1991). It's easier for the bulls now: Official statistics and social change in a Canadian heroin-using community. *The Journal of Drug Issues, 21,* 83-103.

Watts, W.D. (1988). Reducing adolescent drug abuse: Sociological strategies for community practice. *Clinical Sociology Review, 7,* 152-71.